BANKERS INSURANCE COMPANY

P. O. Box 15707., ST. PETERSBURG, FLORIDA 33733
TELEPHONE: (866) 987-9844 FAX: (727) 803-2094
WEBSITE: www.BankersHealthPlans.com

Application Submission Checklist

Agents Name:______________________ Phone Number:______________________

Agent's Email Address:______________________ Fax:______________________

Applicant Name:______________________ Effective Date:______________________

County:______________________ PEO Client: Yes / No If yes-Client Name:______________________
(If YES, use PEO section below)

*** Please include the proposal with your submission***

LIMITED BENEFIT HEALTH

- ❑ Application for Coverage
- ❑ Replacement and Disclosure Form
- ❑ 1st Month Premium Check or Credit Card Auth
- ❑ Authorization for Payment by Credit Card or Bank Withdrawal (if applicable)
- ❑ Application for Network Access Card (Optional)

ERISA STOP LOSS APPLICATION

Note: The ERISA Stop Loss application is a two-step process. You will be contacted by underwriting for additional information, as needed.

- ❑ Request for Proposal
- ❑ Census
- ❑ Current and Renewal Rates
- ❑ Schedule of Current Plan Benefits

INDIVIDUAL MAJOR MEDICAL

- ❑ Application for Coverage
- ❑ 1st Month Premium Check or Credit Card Auth
- ❑ Authorization for Payment by Credit Card or Bank Withdrawal (if applicable)

PEO Clients

Note: Do not send in the Payroll Deduction form to Bankers Employer Services. Bankers Health Plans will forward once application for coverage has been approved.

- ❑ Application for Coverage
- ❑ Replacement and Disclosure Form
- ❑ Application for Network Access Card (Optional)
- ❑ Employee Authorization for Health Plan Payroll Deduction
- ❑ Pre or Post Tax Deductions? (If Pretax, Client must have Section 125 or elect BES Section 125)

- Quotes for Individual Major Medical, and Limited Benefit Health Plans - log on to ***www.BankersHealthPlans.com*** and sign on with your name. Your Bankers Health Plans agent number is your password.
  - *If you are not a Bankers appointed agent or need your agent number, please call us, 866-987-9844 prompt #1 to obtain your password.*
- Submit Applications to Bankers Health Plans - Attn: Underwriting by Fax (727) 803-2094, send original documents and check to Bankers Health Plans - Attn: Underwriting, P. O. Box 15707, St. Petersburg, FL 33733.
- Confirmation of application receipt will be sent via email within one business day. Underwriting decisions will be sent within five business days after *all* requirements are received.
- Questions on our plans, please contact Bankers Health Plans, 866-987-9844
  Vice-President of Health Plan Sales – David Harting (x4224) or
  Underwriting Manager – Pete Collins (x4157)

BANKERS INSURANCE COMPANY

11101 ROOSEVELT BOULEVARD N., ST. PETERSBURG, FLORIDA 33716

LIMITED BENEFIT HEALTH INDEMNITY APPLICATION

Part A: Personal Data *Please Print in Black Ink*

Primary Insured		Date of Birth / /	Age	Sex	Height	Weight	SSN
Residence Address		City		County		State	Zip Code
Residence Telephone	Business Telephone	Occupation		Best Time To Call: a.m. p.m.			State of Birth

Part B: Coverage

Select Benefits Desired	
Plan 1 ❑ In-Hospital Confinement Benefit - $300/day Surgery & Anesthesia Benefit Schedule - $1,000 Outpatient Physician Office Visit Benefit - $25/visit Outpatient Diagnostic X-ray & Lab. Benefit - $25/test Off-the-Job Accidental Injury Benefit-$300 /maximum Outpatient Prescription Drug Benefit - $10/script	**Plan 2** ❑ In- Hospital Confinement Benefit - $600/day Surgery & Anesthesia Benefit Schedule - $2,000 Outpatient Physician Office Visit Benefit - $50/visit Outpatient Diagnostic X-Ray & Lab Benefit - $50/test Off-the-Job Accidental Injury Benefit - $600 /maximum Outpatient Prescription Drug Benefit - $20/script
Plan 3 ❑ In-Hospital Confinement Benefit - $1,000/day Surgery & Anesthesia Benefit Schedule - $ 3,335 Outpatient Physician Office Visit Benefit - $83/visit Outpatient Diagnostic X-ray and Lab. Benefit - $83/test Off-the-Job Accidental Injury Benefit - $1,000/maximum Outpatient Prescription Drug Benefit - $33 /script	

Yes	No	Optional Additional Benefits	
		In Hospital & Surgical Additional Indemnity Benefit	❑ 1,000 per confinement
		Wellness Benefit	❑ $25 ❑ $50 ❑ $75 ❑ $100 per year
		- Waiting Period	❑ 6 months ❑ 12 months
		Daily Intensive Care In-Hospital	❑ $600 ❑ $1,000 ❑ $1,500 per day

Premium Mode: ❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually | Mode Premium Amount: $________________

Additional Proposed Insureds	Relationship	Occupation	SSN	Sex	Date of Birth	Age	Height	Weight	Marital Status
					/ /				
					/ /				

Part C – General History-

To the best of your knowledge and belief:

1. Based on a physician's advice, diagnosis or treatment, are all proposed insureds now in good health and free from any physical or mental disease or defects? .... ☐ **Yes** ☐ **No**
2. Have you or any person proposed for coverage tested positive for exposure to the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) cause by the HIV infection or other sickness or condition derived from such infection? .... ☐ **Yes** ☐ **No**
3. In the last 5 years have you any person proposed for coverage been diagnosed by a physician, treated by a physician, or had a physician recommend testing for any:
   a. Disease or disorder of the heart, blood or circulatory system; stroke; cancer; diabetes? .... ☐ **Yes** ☐ **No**
   b. Disease or disorder of the respiratory system, including emphysema or asthma? .... ☐ **Yes** ☐ **No**
   c. Disease or disorder of the rectum, kidney, prostate, intestine, liver, or hepatitis?.......... ☐ **Yes** ☐ **No**
   d. Disease or disorder of the nervous system, brain, back or spine; paralysis; stroke; severe arthritis; epilepsy; mental or nervous disorder; alcohol or drug abuse?.......... ☐ **Yes** ☐ **No**
4. Have you or any person proposed for coverage been hospitalized in the last 12 months or been recommended for medical or surgical treatment, testing, or hospitalization by a physician that has not yet been done?.......... ☐ **Yes** ☐ **No**

Continue to the next page to complete this application for insurance

Part C – General History- (Cont.)

5. Have you or any person proposed for coverage been diagnosed by a licensed physician as currently pregnant, an expectant parent or currently undergoing fertility treatment? .... ☐ **Yes** ☐ **No**
6. Is this coverage intended to replace existing coverage; or have you applied for or do you currently have in-force any other medical insurance coverage?... ☐ **Yes** ☐ **No**
   If so, please provide name of insurance company and policy number:________________________
7. List all current physician prescribed medications (Use a separate sheet of paper for additional information).

Proposed Insured	Medication	Reason for Taking / Condition Treated	Date Prescribed	Date Last Taken

Provide details to YES answer to Questions 1-5 and NO answer to Question 6 (Use a separate sheet of paper for additional information).

Question	Proposed Insured	Details / Results

Part D: Agreement: I (We) represent, to the best of my belief, that all statements and answers contained in this application, and in any supplements required by Bankers Insurance Company (BIC) are complete and true**.** ***I (We) expressly agree that no insurance is in effect as a result of this application unless: (a) the application is approved by BIC; and (b) a policy has been issued by BIC; and (c) the policy has been manually received and accepted by the Primary Insured; and (d) the first modal premium has been paid; all during the lifetime and continued insurability of the Primary Insured.***

I (We) hereby acknowledge receipt of the completed Outline of Coverage for the above plan of insurance.

Part E: Authorization: I (We) hereby authorize any hospital, Veterans Administration Hospital, physician, company, institution or person who has attended or examined any Proposed Insured, to disclose when requested by BIC or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. I (We) hereby, further authorize any past or present employer to release information when requested by BIC or its representative. I (We) understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected under federal privacy regulations. I (We) may revoke this authorization by notifying BIC in writing of my (our) desire to revoke it. However, I (We) understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization will expire 180 days from the date of my (our) signature(s). A photocopy of this authorization shall be considered as valid as the original. ***Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony in the third degree.***

I (We) hereby declare the application was signed and dated at______________________________**on**_____/____**20**_____

City / State Month / Day Year

________________________ Primary Insured Signature

________________________ Spouse Signature (if applicable)

Part F: Agent's Statements - I hereby certify that: (a) I personally asked the questions contained in this application of the Proposed Insured(s) and duly recorded the answers; and (b) to the best of my knowledge there is nothing adversely affecting the insurability of the Proposed Insured; except as stated on the application; and (c) if the initial premium was paid with the application, I have remitted it to Bankers Insurance Company; (d) if disclosure statement or replacements notices are required by the State, I have given them to the Proposed Insured(s); and, (e) a completed Outline of Coverage has been delivered to the applicant(s).

To the best of my knowledge, replacement of an existing insurance policy ☐ is ☐ is not involved in this transaction.

Did you personally see the Proposed Insured(s) complete and sign the application? .... ☐ Yes ☐ No

Did you personally ask the Proposed Insured(s) the application questions and completely record the answers? ..... ☐ Yes ☐ No

________________________ Agent Name (print)

________________________ Agent Signature

________________________ Date

________________________ Agent Number

________________________ FL License #

HOME OFFICE USE ONLY:

Rate:______________________________ Reviewed:______________________________

BANKERS INSURANCE COMPANY

11101 ROOSEVELT BOULEVARD. ST. PETERSBURG, FLORIDA 33716
Telephone (866) 987-9844 Fax: (727) 803-2094

Replacement and Disclosure Form - Limited Benefit Medical Plan

A subsidiary of Bankers Financial Corporation

This is an Indemnity Plan that pays benefits based on a set dollar amount. This plan is not a major medical plan, and therefore the benefits are limited.

Please review all materials you have been provided in making your decision to purchase this plan.

If you are replacing your existing medical insurance, this insurance plan does not provide protection under HIPAA for portability of coverage or credit for prior coverage. This may affect coverage for any pre-existing conditions you may have.

It has been explained to me, and I understand that this is a Limited Benefit Medical plan and is not comprehensive major medical coverage. I understand the terms of coverage, benefits and exclusions of the Limited Benefit Medical Plan. I also understand that if I purchase a health plan that excludes or reduces coverage for certain services, treatment or conditions, I may be limiting my ability to obtain individual insurance coverage for that condition, in the event the health of any individual covered under the plan changes.

____
Signature of Applicant

____
Name of Applicant

____
Address

______________________ ____________________ _______________
City State Zip Code

____
Date

Note: This form must be retained by the carrier issuing the policy and a copy given to the applicant upon application.

BANKERS INSURANCE COMPANY

11101 ROOSEVELT BOULEVARD N., ST. PETERSBURG, FLORIDA 33716

Authorization for Payment by Credit Card or Automatic Bank Withdrawal

Applicant's Full Name			
Street Address	City	State	Zip Code

Coverage Period: ______ Months	Payment Method: ☐ Credit ☐ Automatic Bank Withdrawal

Monthly Premium	Credit Card Transaction Fee	**Total Monthly Withdrawal**
$ +	$ * (Add 2% for payments by CC) (Auth must be received by the 20th of the month)	**$**

CREDIT CARD PAYMENT REQUEST:
I authorize Bankers Insurance Company to bill my:

☐ Visa ☐ MC account(s) for __12__ months of monthly premiums/fees.

* A 2% transaction fee applies when payment is made by Credit Card. Information must be received by the 20th of the month to set up credit card payment for the first of the next month.

Name on Card: ________________________

List Digits of account: ________________

____
Expiration Date:

____
Signature of Cardholder Date

AUTOMATIC BANK WITHDRAWAL REQUEST:
By selecting automatic bank withdrawal, your monthly premium will automatically be withdrawn from your account. Complete the form below and include a voided check, with the Application Form and the initial premium.

Name of bank: ____

Address of bank/branch: ____________________________________

Bank routing number: ____________ Account number: ____________

Account type: ☐ Checking (please attach a voided check) ☐ Savings

Name of bank depositor/account holder: ______________________

I request that you pay and charge my account debits drawn from the account by Bankers Insurance Company to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advance written notice to me and to Bankers Insurance Company. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: ________________________________

Date: ____

BANKERS INSURANCE COMPANY

11101 ROOSEVELT BOULEVARD N., ST. PETERSBURG, FLORIDA 33716
Telephone: (866) 987-9844

LIMITED BENEFIT HEALTH INDEMNITY POLICY

OUTLINE OF COVERAGE

(Policy LBMP-IND-OC)

NOTICE TO BUYER
This is a Limited Benefit Health Indemnity Policy. This Policy provides limited benefits. Benefits provided are not intended to cover all medical expenses.

Read your policy carefully. This outline provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and us. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

Renewability Your policy is guaranteed renewable. The premium can be changed only if we change it on all policies of this kind in force in the state where the policy was issued. If your premium is changed, you will be given 45 days notice.

This coverage is designed to provide, to persons insured, coverage in the form of a fixed amount of benefits for medical expenses resulting from a covered injury or sickness, subject to any limitations set forth in the policy. Coverage is not provided beyond the fixed amounts shown below.

We will not deny the issuance or renewal of, limit coverage or cancel your policy solely because the Covered Person has been diagnosed as having a fibrocystic condition or nonmalignant lesion that demonstrates a predisposition. We will not deny the issuance or renewal of, limit coverage or cancel your policy solely due to the family history of the Covered Person related to breast cancer, or solely due to any combination of these factors, unless the condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer.

We will not deny the issuance or renewal of, or cancel a policy nor limit benefits solely due to breast cancer, if the Covered Person has been free from breast cancer for more than 2 years before the application for this health insurance coverage.

BENEFITS

Daily In-Hospital Indemnity Benefit.
We will pay the amount selected for hospital confinement as an inpatient for each day an insured person is confined to a hospital for each one period of confinement, subject to the maximum benefit period specified in the Schedule of Benefits. Confinements separated by less than 30 days will be considered one period of confinement. Before benefits are payable, the hospital confinement must;

1. Be due to an injury or sickness; and,
2. Begin while this policy is in force for the insured person; and,
3. Be for at least 24 hours; and,
4. Be at the direction of and under the supervision of a physician.

Surgery and Anesthesia Indemnity Benefit.
When a Covered Person undergoes a surgical procedure as listed in the Schedule of Surgical Indemnity benefits due to a covered accident or sickness, We will pay the Benefit shown in the Schedule of Surgical Indemnity benefits. We will also pay the Benefit amount, as shown in the Schedule of Benefits for administration of anesthesia by a Physician in connection with the surgery. If two or more surgical procedures are performed through the same incision or in the same operative field, the benefit will be for only the procedure that has the largest Benefit payable. If more than one procedure is performed, but each through a separate incision or in a separate operative field, the amount payable will be the specified amount for the primary procedure plus 500% of the amount payable for all other surgical procedures performed.

If a surgical procedure is not listed in the Schedule of Surgical Indemnity Benefits, We will pay an indemnity benefit at a rate consistent with similar procedures that are listed in the Schedule of Surgical Indemnity Benefits.

In the event of mastectomy, coverage is provided for all stages of the breast on which the mastectomy has been performed, prosthetic devices and breast reconstructive surgery of the other breast to produce a symmetrical appearance. Coverage is provided for an Inpatient Hospital stay, according to the benefits shown in the Schedule of Benefits, for mastectomies for any period determined by the treating Doctor in consultation with the Insured patient. Outpatient post-surgical follow-up care is provided in accordance with prevailing medical standards by a licensed physician qualified to provide post-surgical mastectomy care, after consultation with the Insured patient.

Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit. When laboratory tests are performed for the purpose of diagnosis of a covered Accident or Sickness as indicated by symptoms that would suggest an Injury or Sickness has occurred, while the Covered Person is not Confined to the hospital, We will pay the benefits shown in the Schedule of Benefits. This benefit is limited to the Maximum Number of tests per Calendar Year shown in the Schedule; except for preadmission testing for which the benefit is payable once per each hospital confinement of a Covered Person.

Outpatient Physician Office Visit Indemnity Benefit. We will pay the Outpatient Physician Office Visit Indemnity Benefit shown in the Schedule, for a Physician office visit due to Accident or Sickness. For each Calendar year, the total amount paid under this benefit will not exceed the Maximum Number of Office Visits per Calendar Year shown in the Schedule of Benefits.

Off-the-Job Accidental Injury Benefit. Benefits are payable for actual charges incurred, up to the amount shown in the Schedule of Benefits for each Covered Person, for x-rays required to diagnose an Accidental Injury and treatment of a covered Accident by a Physician in the Physician's office, clinic, or urgent care facility or Hospital emergency room. Treatment must be received within 72 hours of such Accident for benefits to be payable. This Benefit is not to exceed the maximum Number of Occurrences per person per Calendar Year shown in the Schedule of Benefits.

When a Covered Person requires ambulance transportation to a Hospital or emergency center for injuries sustained in an Off-the-Job Accident, we will pay the Benefit shown in the Schedule of Benefits. This Benefit will be paid for the maximum number of occurrences per Calendar Year and subject to the Lifetime Maximum Benefit shown in the Schedule of Benefits. Ambulance transportation must be within 72 hours of the Accident, and be provided by a licensed professional ambulance company.

Prescription Drug Indemnity Benefit. When a Covered Person incurs expenses for prescription drugs, when such drugs are prescribed by a Physician, as a result of an Accident or Sickness, we will pay the amount specified in the Schedule of Benefits. This Benefit will be paid for the Maximum Number of prescriptions per Calendar year as shown in the Schedule of Benefits.

OPTIONAL BENEFITS

Wellness Benefit. This Benefit provision applies if it is shown in the Schedule of Benefits.
We will pay the amount shown in the Schedule of Benefits for each Covered Person, after satisfaction of the Waiting Period shown in the Schedule of Benefits, who has undergone mammograms, pap smears, prostrate-specific antigen tests, physical examinations, and blood screenings. This Benefit is payable only once each 12-month period for each Covered Person. However, with physician recommendation, We will pay for more than one annual mammogram for any woman who is designated at risk for breast cancer due to personal or family history of medically diagnosed breast cancer by a physician. We will pay for well-child care including immunizations for children up to age 6.

In-Hospital and Surgical Additional Indemnity Benefit. This Benefit provision applies if it is shown in the Schedule of Benefits.
When a Covered Person receives treatment or surgery while Confined in a Hospital as an inpatient as a result of an Accident or Sickness, we will pay the amount specified in the Schedule of Benefits for each Covered Person. This Benefit will be paid for the maximum number of Confinements per Calendar year as shown in the Schedule. No Benefit will be paid for any period of Confinement during which the Covered Person is not under the regular care and attendance of a Physician.

Intensive Care Benefit. This Benefit provision applies if it is shown in the Schedule of Benefits.
When a Covered Person is confined in an Intensive Care Unit ("ICU")of a Hospital for a covered Accident or Sickness, Benefits are payable up to the amount shown in the Schedule of Benefits for each day of the Covered Person's Intensive Care Confinement. The Benefit requires a 24- hour Hospital stay. Benefits are payable in addition to Daily Hospital Confinement Benefit.

If There is a Break in Service. In the event a Covered Person's coverage terminates for any reason, and such person re-applies for coverage under this Policy or any other Bankers Insurance Company like Policy, all Benefits paid during the Calendar Year will be aggregated and applied towards the maximum benefit for that Calendar Year as described in the Schedule of Benefits, regardless of how many times a Covered Person becomes insured under this or any other like Bankers Insurance Company policy. In addition, the Pre-Existing Condition Limitation provision will apply to its full extent if such re-application does not occur within 60 days after the most recent termination. If re-application does occur within 60 days after the most recent termination, the Pre-existing Condition Limitation will be waived to the extent that such Covered Person had satisfied the provision during the prior coverage period.

EXCLUSIONS AND LIMITATIONS

This Policy will not provide Benefits for or as a result of any of the following:

1. Preventive Services which are not Medically Necessary for the treatment of Illness or Injury.
2. Any treatment, service or supply, which is not due to an Illness or Injury;
3. suicide or any attempt of suicide while sane or insane
4. any intentionally self-inflicted Injury or Sickness or any attempt thereat
5. committing, attempting to commit, or taking part in a felony, battery, assault, or engaging in an illegal occupation
6. declared or undeclared war or acts thereof (does not include terrorism)
7. participation in a riot, insurrection, rebellion, civil commotion, civil disobedience, or unlawful assembly.
8. flying as a pilot, crew member, or passenger in any aircraft, except as a fare-paying passenger in any regularly scheduled commercial aircraft flying between established airports on a regularly scheduled route
9. rest care or rehabilitative care and treatment
10. routine newborn care, such as Hospital and Physician services during Hospital Confinement immediately following birth
11. immunization shots and routine examinations such as: physical examinations, mammograms, pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings, unless the Wellness Benefit is elected and shown on the Schedule of Benefits
12. hearing aids or fitting of hearing aids
13. routine eye examinations or fitting of eye glasses
14. the treatment of:
    a. mental illness
    b. functional or organic nervous disorder, regardless or cause
    c. alcohol abuse
    d. drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed In such circumstances, and with respect to payment of the Daily In-Hospital Indemnity Benefit, benefits will be limited to no more than 10 days in any Calendar Year.
15. participation in:
    a. motor vehicle or other power driven speed racing
    b. parachuting
    c. parasailing
    d. bungee jumping; or
    e. hang gliding
16. any procedure or treatment to change physical characteristics to those of the opposite sex and other treatment related to sex change
17. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician's service, unless required by law
18. Pre-existing Conditions during the first 12 months after the Effective date
19. tubal ligation or vasectomy reversal
20. any loss incurred while on active duty status in the armed forces (if You notify Us of such active duty, We will refund any premiums paid for any period for which no coverage is provided as a result of this exception)
21. any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred)
22. Accident or Sickness arising out of and in the course of any occupation for compensation, wage or profit OR expenses which are paid under Occupational Disease Law or similar law, whether or not application for such benefits has been made
23. dental examinations or dental care other than expenses resulting from an Accident
24. care or treatment of an Accident or Sickness not specifically provided for in this plan
25. cosmetic surgery or care or treatment solely for cosmetic purposes or complications from such surgery, care or treatment. This includes but is not limited to: reconstructive surgery and prosthetic devices, unless incident to mastectomy or, unless due to an Accident and performed within one year from the Accident or to repair a congenital or abnormal defect of a newborn child, while covered under the Policy

26. voluntary abortion, except with respect to You or covered Dependent spouse: a) where such person's life would be endangered if the fetus were carried to term; or b) where medical complications have arisen from an abortion
27. dependent child maternity
28. unless specifically provided for in the Policy, treatment of obesity, weight reduction or dietetic control; except morbid obesity or disease etiology
29. unless specifically provided for in the Policy, charges for Outpatient food, food supplements or vitamins;
30. unless specifically provided for in the Policy, charges for services in the nature of educational or vocational testing or training
31. any charge for which there is no legal obligation to pay; no charge is made; or in the absence of coverage, no charge would be made
32. charges for services provided outside the scope of the license of the institution or practitioner rendering the service
33. charges made by, durable equipment recommended by, or drugs dispensed by; a physician, surgeon, nurse or other doctor who: a) normally lives with the Insured Person; or b) is a member of the Insured Person's family.
34. charges for stand - by surgeons, pediatricians, anesthesiologists, anesthetists, or other doctor as defined by the plan, or stand- by supplies, equipment, rooms, or any other service, supply or treatment not actually used in the care or treatment of an Accident or Sickness
35. charges related to smoking cessation
36. air, water, ground ambulance service unless specifically provided for in the Policy
37. with respect to the Off-the –Job Accidental Injury Benefit only, charges that the Covered person is not legally required to pay, or charges which would not have been made if this coverage had no existed
38. prescription drugs unless specifically provided for in the Policy
39. any procedure intended to enhance an Insured Person's quality of vision that is not essential to the treatment of a Sickness or Injury, unless specifically provided for in the Policy.
40. with respect to experimental or investigational treatment or surgery, except covered bone marrow transplant procedures will not be considered experimental if the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental as specified by the Agency for Health care Administration.
41. diagnostic and surgical procedures, including but not limited to, diagnostic laboratory and pathology procedures, diagnostic radiology, nuclear medicine and ultra sound procedures unless specifically provided for in the Policy.
42. charges for Intensive care unless specifically provided for in the Policy.
43. charges for medical care, services or supplies that are not furnished or prescribed by a Physician
44. charges for care or service furnished by an agency or program funded by federal, state or the government. This does not apply to Medicaid or where prohibited by law.
45. charges which are not related to and consistent with the treatment of any Accident or Sickness of the Insured person.

PRE-EXISITING CONDITION LIMITATION

Pre-existing Condition - We do not cover Pre-Existing Conditions.
Pre-existing means the existence of symptoms which would cause an ordinarily prudent person to seek medical diagnosis, care or treatment during the twelve (12) months prior to the Effective Date of his/her coverage; or, a condition for which medical treatment or advice was rendered or recommended by a licensed Physician within twelve (12) months prior to the Effective Date of the Insured person's coverage. An Injury or Sickness will no longer be considered Pre-Existing after the expiration of 12 consecutive months commencing on or after the Effective Date of the Insured Person's coverage during which period there has been no medical treatment or advice rendered or recommended for such Injury or Sickness.

Routine follow up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice or treatment for the purposes of determining pre-existing conditions unless evidence of breast cancer is found during or as a result of follow up care.

TO OBTAIN INFORMATION OR MAKE A COMPLAINT, YOU MAY CALL OUR TOLL FREE NUMBER: 1-866-987-9844.